Commonwealth of Virginia
Department of Social Services

Neighborhood Assistance Program
Services Contribution Data Sheet
(To be completed and submitted with the CNF-H)
(Print)

To Be Used For Donated Physician Specialist Services to patients who are referred from an approved organization whose sole purpose is providing specialty medical referral services to patients of participating clinics or federally qualified health centers regardless of where the services are delivered.

(Please use a separate form for each clinic)

NAME OF DONOR: _____

ADDRESS: _____

NAME OF NAP ORGANIZATION_____

Contact Info Of Clinic Where Services Were Provided	**DATE** (List each date separately)	**HOURLY RATE** (excludes fringes)	**TOTAL HOURS WORKED**	**TOTAL VALUE** (Rate x Hours)
Federal ID#_____ _____ Name of Clinic or Federally Qualified Health Center _____ Address of Clinic _____, VA _____ City ZIP Code _____ Phone				

NOTE: Other formats providing the same information will be accepted. Sign and attach this form to the CNF or other format and return to the NAP Organization.

CERTIFICATION BY PHYSICIAN SPECIALIST: I certify that the value of the donated service(s) was determined by the standards stated in the instructions and does not exceed the statutory maximum. I also certify I will not receive any type of compensation or reimbursement from medical insurance filing or from my company for the donated service(s) nor will my company receive any compensation. I understand that if I falsify information, I may be subject to penalties prescribed by the Virginia Departments of Taxation and Social Services.

_____ _____
Date Signature of Donor